OAK LAWN COMMUNITY HIGH SCHOOL
PERMISSION FORM FOR PRESCRIBED MEDICATION
(All Items must be completed in detail by the physician)

Student's Name _____ Date of Birth _____

Name of Medication _____

Diagnosis requiring medication _____

Reason for medication during school hours _____

Date of prescription _____ Discontinuation date _____

Dosage: _____ Route: _____ Frequency and Time of Administration: _____

Intended effect of medication: _____

Side effects from medication for which student must be observed: _____

_____

This student is both capable and responsible for self administering this medication. ( ) No ( ) Yes/Supervised

This student may carry this medication (For Inhaler and Epi-Pen use only) ( ) No ( ) Yes

Other medications the student is receiving: _____

Time interval for re-evaluation: _____

LICENSED PRESCRIBER:

Prescriber Name _____ Prescriber Phone/Emergency # _____
(printed)

_____
(Signature and Stamp) (Date of Signature and Order)

PARENTAL AUTHORIZATION: I hereby authorize Oak Lawn Community High School and its employees to administer to my child lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is administered, I waive any claims I might have against District #229 and its employees arising out of the administration of said medication. In addition I agree to hold harmless and indemnify District #229and its employees from and against all claims, damages, and causes of action or injuries incurred or resulting from the administration of said medication.

Parent/Guardian Name _____ _____
(Please print) (Signature) (Date)

Telephone # _____ Emergency # _____